Exhibit A

SALARY REDUCTION AGREEMENT
under the
CHERRY HILL TOWNSHIP FLEXIBLE BENEFIT PLAN
ELECTION/CHANGE FORM

To: Cherry Hill Township

Effective __1/1/2027___ (insert date salary reduction is to commence). I request my employer to reduce my taxable wages by the health insurance withholding amounts for the fiscal year. I understand that this total amount will be deducted pro-rata during each payroll period over the year. The amount of this total reduction shall be allocated to my spending accounts as follows (check the spending account desired):

☐ Health / Dental / Prescription Premium Conversion Spending Account. I request that my taxable wages each pay period be reduced by my share of any Health insurance premiums payable under any employer-sponsored health plan in which I am a participant and that my employer use the salary-reduced amounts to pay my share of the premiums. I understand that my salary reductions for this benefit will automatically change due to changes in the premium arrangements (e.g., an increase in premiums or an increase in the share of these premiums I may have to pay).

☐ Initial yearly election

☐ Revision Change in status (check one)

- ☐ Legal Marital-Marriage, Death of Spouse, Divorce, Legal Separation or Annulment.
- ☐ # of Dependents-Birth, Adoption or Death.
- ☐ Employment-Termination or commencement by Employee, Spouse or Dependent.
- ☐ Work Schedule-P/T, F/T, Strike, Reduction or increase in hours or unpaid leave.
- ☐ Change in Dependent's Status-Requirements for Coverage Due to Age, Student Status or Similar Circumstances.
- ☐ Residence or Worksite-Change for Employee, Spouse or Dependent.
- ☐ Cobra, Medicare or Medicaid
- ☐ Judgment, Decree or Order.
- ☐ Change in Cost of Coverage

☐ I do not wish to participate

I understand that this agreement is irrevocable except for certain changes specifically set forth in the plan documents. The amounts cannot be transferred from one account to another, carried over beyond the year to which this agreement relates or returned to me in cash or other remuneration. Failure to return this form will constitute a Default Election of Premium Conversion.

Dated: _____

_____ _____
Please print Employee's Name Employee Signature

For Administrator Use Only

Accepted on behalf of the Employer by: Dated: _____

_____
Signature of Employer
Authorized Representative

CHERRY HILL TOWNSHIP

WAIVER UNDER CAFETERIA PLAN OF PARTICIPATION

WHEREAS, in accordance with the cafeteria plan (the "Plan"), the Employee has elected to waive coverage for himself or herself and his or her eligible dependents of the health plans which the Employee would otherwise be entitled to receive, and

WHEREAS, such waiver is knowing and voluntary on the part of the Employee;

Please choose the following insurance plans to opt out:

☐ Health Insurance
☐ Dental Insurance
☐ Prescription Insurance

NOW, THEREFORE, in consideration of the promises contained herein, and subject to the provisions of the Plan, it is hereby agreed as follows:

l. Waiver of Participation in the selection of one or more above - In accordance with the Plan, the Employee, for himself or herself, his or her heirs, assigns, successors, spouse, and dependents hereby waives any right on his or her part of his or her part and the part of his or her spouse and dependents to participate in the benefits maintained by the Employer. In making this knowing and voluntary waiver, Employee on behalf of himself or herself, his or her spouse and dependents understands and agrees that they will have no coverage or benefits whatsoever under the selected plan(s) from above and that this waiver may not be revoked during the plan year, except to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

2. Release and Indemnification - The Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents covenants and agrees never to make a claim under the insurance plan(s) selected above and further fully releases the Employer, its officers, directors, employees and agents and insurance carriers from any liability arising in connection with any claim by the Employee, his or her heirs, assigns, successors, spouse and dependents for any benefits or coverage under the above selected plan(s), and the Employee, for himself or herself, his or her heirs, assigns, successors, spouse and dependents agrees to defend and indemnify the Employer, its officers, directors, employees and agents from any liability, loss, damages, costs or expenses (including, but not limited to, attorneys' fees) arising in connection with this Waiver or any claim for benefits or coverage under the above selected plan(s). The employee also agrees to sign any waiver required by the State Health Benefits Program Coverage.

3. Waiver Irrevocable During the Plan Year, Except Upon a Change in Status or in the Event of Retirement - Employee acknowledges and agrees that his or her decision to enter into this Waiver is knowing and voluntary, that he or she fully understands all the provisions of this Waiver and that this Waiver may be revoked during the plan year only to the extent permitted under the Plan in the event of a change in status or in the event of retirement.

The following events are considered a change in status:

1. legal marital status - marriage, death of spouse, divorce, legal separation or annulment;
2. number of dependents - birth, adoption, placement for adoption or death of a dependent;
3. employment status - termination or commencement of employment by the employee, spouse or dependent;

4. work schedule - including a switch between part-time and full-time, a strike or lockout, a reduction or increase in hours or unpaid leave of absence;

5. change in dependent's status - a dependent satisfies or ceases to satisfy the requirements for coverage due to age, student status or similar circumstances;

6. residence or worksite - a change in the place of residence or work of the employee, spouse or dependent.

4. No Representations by Employer as to Possible Tax Consequences - Employer has made no representations to Employee with regard to the tax consequences of this Agreement and the Employer shall have no liability with regard to any such tax consequences.

5. Certification of Other Insurance - The Employee hereby certifies that he or she has existing and in effect other health and hospitalization insurance which provides coverage for himself or herself and for his or her eligible dependents.

6. Sealed Instrument - This Agreement shall constitute a sealed instrument under New Jersey law.

IN WITNESS WHEREOF, the Employee designated below has entered into this Waiver this _____, 20__.

The Employee

_____	_____	_____
(Signature)	Print Name	Date

INSURANCE REBATE REQUEST

Full time employees who are eligible for Township health benefits may elect to receive a rebate if they waive medical/prescription and/or dental coverage. Rebate amounts are as follows:

MEDICAL	
Family	$2,000.00
Employee and Spouse	1,500.00
Parent and Child(ren)	1,200.00
Single	1,000.00
PRESCRIPTION	
Family	$ 435.00
Employee and Spouse	378.00
Parent and Child(ren)	274.00
Single	239.00
DENTAL	
Family	$ 184.00
Employee and Spouse	122.00
Parent and Child(ren)	122.00
Single	82.00

Eligibility requirements: Rebate eligibility criteria is the same as benefit eligibility criteria for health insurance purposes. The following requirements must be met:

- Spouses – Employee and spouse must be currently legally married and file taxes as married/jointly or married/separately.
- Children under the age of 2 do not qualify as dependents for dental rebate purposes.
- Children between the ages of 19 and 23 must be enrolled as full-time students to qualify as dependents for dental rebate purposes.
- Children over the age of 26 are not considered dependents for medical, dental, or prescription rebate purposes.

Employees must also complete a Waiver Under Cafeteria Plan of Participation Form and submit copies of applicable dependent verification documents (marriage cert., recent 1040 tax form, birth certs.).

INSURANCE REBATE REQUEST **NEW** ☐ **UPDATE** ☐
(check one)

EMPLOYEE: _____

I am waiving the health benefits checked below and would like to receive a health benefit rebate.

MEDICAL	**PRESCRIPTION**	**DENTAL**
☐ Family	___ Family	___ Family
☐ Employee/Spouse	___ Employee/Spouse	___ Employee/Spouse
☐ Parent/Child	___ Parent/Child	___ Parent/Child
☐ Single	___ Single	___ Single

Amount of rebate: $_____ / Annual, paid quarterly (pre-tax dollars)

Payment is made quarterly for the preceding three months.

By signing below, I certify that I have health insurance coverage currently effective with another health insurance policy/carrier. I also certify that I am eligible for the coverage that I have selected to waive and will notify the Human Resources Department immediately of any changes in my eligibility status.

_____ _____
Signature Date